SOUTHEASTERN VIRGINIA TRAINING CENTER
September 2-3, 2004
OIG Report#103-04

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Southeastern Virginia Training Center during September 2-3, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. These include: mission and values, access, service provision, facility operations and community relationships. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff, and directors of mental retardation services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. This report is divided into five primary sections focusing on each of the domains.

SOURCES OF INFORMATION: Interviews were conducted with thirty (30) members of the staff including administrative, clinical and direct care staff. Tours were conducted in selected residential cottages and in on-site day treatment/training program buildings. The documentation reviewed included, but was not limited to: three (3) clinical records, approved behavioral plans, selected policies and procedures, staff training curriculums, the facility quality management plan, selected minutes of the risk management committee, and the SEVTC budget presentation.

MISSION AND VALUES

1. The facility has a clear mission statement.

It was reported by the numerous staff interviewed that the facility does not have a formally defined mission statement. However, the team was provided a copy of the facility brochure that had a mission statement included in its text. The brochure indicates that the mission "is to provide habilitation, training, educational and health services for eligible persons from Planning Districts 17, 18, 19, 20, 21, and 22."

Twenty staff members were asked to define the facility's mission. Most described the mission from the vantage point of their positions or the mission of their duties or unit. In addition, fifteen of the twenty individuals interviewed described the mission in terms of addressing the basic care needs of the residents such as proving safe housing, quality healthcare, proper nutrition, adequate clothing and recreational opportunities. Even though nineteen of the twenty staff persons interviewed indicated that addressing the training needs of the residents was a key element of the facility's mission, only seven linked the goal of the facility's services to the development of skills necessary for

community placement. Some senior clinical staff reported being unsure what the mission of the facility is at this time. It was stated that the population of the facility has shifted so dramatically over the past ten years, yet the programming continues to be designed for persons less behaviorally and physically challenged than those who are currently served.

It is of concern that there is widespread unawareness of the facility's formal mission statement and a lack of consistent understanding of the mission.

2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.

The facility brochure outlines that SEVTC subscribes to a philosophy that emphasizes "the importance of programming based on individual needs and the inherent right of every human being to dignity, respect, protection and the right to contribute to society according to his or her abilities."

Those interviewed identified teamwork, dignity and respect, adherence to professional standards and the provision of quality care in a safe home-like environment as the predominant values governing the services delivered by the facility. Administrative staff indicated that the facility subscribes to the normalization principle and that residents are entitled to the highest quality treatment that can be provided within the available resources. The team observed staff and resident interactions during the facility tours. Staff were noted to treat the residents in a professional yet caring manner.

Staff across the campus reported very different experiences regarding how often they see the facility director in their program areas. This ranged from every couple of weeks to every several months.

ACCESS / ADMISSIONS

1. Policies and Procedures that govern admission are consistent with the facility's mission statement.

The OIG could not make a determination regarding this quality statement because the facility did not present a formalized written mission statement to the team at the time of the inspection.

2. Admission to the facility is based on a thorough assessment of each applicant's needs and level of functioning.

SEVTC Instruction Number 2001 provides the guidance for admissions to the facility. Four staff members were interviewed regarding the admissions process, which all described as "fairly standard across the system". Staff related that the 2003 Admission and Discharge Protocols serve as the basis for their admissions and discharge processes. SEVTC has a committee that provides oversight of the admissions process, including

making recommendations to the facility director regarding whether the applicant is appropriate. A social worker/community liaison works with the appropriate placing agency to obtain the necessary information by which the committee will determine the applicant's suitability for acceptance (SEVTC Instruction Number 2000). This includes such information as a recent psychological, family and social history, and medical information. Once the committee has submitted its recommendations, the facility director makes a final determination regarding the applicant's suitability for admission. It is the responsibility of the facility director to advise the appropriate CSB of the outcome of the admissions review. A notification letter is sent outlining the decision. In the case where the application is rejected, the letter states the reasons for the denial and provides suggestions for either alternate placement or other services.

Upon admission, the new residents will undergo a series of assessments by the various disciplines within the facility. The assessments serve as the basis for the individualized habilitation plans. All three (3) of the records reviewed contained the assessments described by policy. The record reviews demonstrated that the assessments and identified needs of the resident serve as the basis for the development of the plans.

Five (5) regular admissions had been completed to the facility during the past year. It was reported that at the time of the inspection there were three (3) additional approved admissions awaiting a space in the facility as of July 1, 2004.

3. The facility has a mechanism in place for addressing emergency admissions.

SEVTC Instruction Number 2014 governs the admission of emergency placements. The instruction defines emergency care as "a legal status assigned to an individual admitted to an MR training center for a limited time without the judicial certification process. Admission is limited to 21 consecutive days or 75 non-consecutive days in a calendar year". It was indicated that the process for acceptance of an applicant as an emergency admission is similar to the regular admissions process, except abbreviated.

Twenty requests for emergency admission were made during the period from 7/1/03 to 7/1/04, of which one was determined suitable for acceptance. Senior staff expressed concern that the facility was not more readily accepting emergency admissions. One senior staff member reported that a number of individuals described as unsuitable for community living because of maladaptive behaviors, such as aggression, have been referred for short-term stabilization and training but not accepted. Examples of community clients that had been turned down, which staff felt could have been served by the facility with special accommodations, were provided to the team.

SERVICE PROVISION / CONSUMER ACTIVITIES

1. Activities are designed to facilitate socialization, skills acquisition and community integration.

The team reviewed three clinical records. All of the records contained individualized goals consistent with the tasks noted in this quality statement.

Tours included a walk-through of a day treatment program and both day and evening cottage based activities. Interviews with staff revealed that even though the scheduled activities were designed primarily for groups, individualized skills training programs were occurring within the prescribed activity. Interviews with the staff and a review of the residents' training workbooks revealed that the trainings were occurring as outlined. For example, during the tours of the cottages that occurred during the evening shift, the primary group activity was entitled Movement to Music. Staff engaged all residents in the activity but spent time with each person working on an individualized task, such as following instructions or increasing gross motor skills. Staff was knowledgeable of the goals and activities for the residents. Staff were observed treating the residents with dignity and respect. Overall the activities were designed to strengthen motor skills, increase communication, facilitate following instructions, support socialization skills and decrease maladaptive behaviors.

The majority of training activities for the residents at SEVTC occur in the residential areas because there is limited space for programming available on campus. The programming space limitation is a distinct disadvantage for the residents at this facility.

2. Residents are actively engaged.

As previously noted, tours were conducted in both residential and training/programming areas. Residents were engaged primarily in groups in each of the areas toured. Because of the limited staffing available, most of the residents were idle while staff were working with one or two persons. The activities varied depending on the level of functioning of the residents. Interviews revealed that approximately 80% of the facility's residents are engaged in some form of pre-vocational or vocational training activity. The number of hours in which each person participates varies depending upon the resident's level of functioning and the work available. One of the challenges facing the facility is maintaining adequate work activities in order to keep the residents actively engaged. The facility continues in its efforts to cultivate "piece-work" opportunities for the residents, however, a number of community organizations that have utilized the facility in the past are no longer doing so.

During the evening tours, after the residents completed their involvement in the movement to music activity, they were observed watching videos, going on a group walk outdoors or resting in their rooms. During this unstructured period, staff were also observed assisting residents with bedtime preparation tasks.

3. Activities occur as scheduled.

Programming was noted to occur as scheduled. Staff was familiar with the schedule and indicated that efforts were made to assure that activities occurred as planned.

4. Residents are supported in participating in off-grounds activities.

Interviews with staff revealed that the residents have opportunities to participate in individual and small group activities in the community, such as going shopping at the local mall, to the area parks, out for rides, attending picnics off grounds and going out for dinner. The team was informed that several residents had traveled to Busch Gardens for the day. This was identified as one of the favorite activities of the residents and staff. Evidence of community integration activities was also noted in all of the client records reviewed.

5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.

Interviews indicated that the facility currently serves residents from thirteen (13) community services boards. Three of the boards have only one resident at the facility. Both a facility social worker and the resident's CSB case manager are actively involved in the coordination of the discharge plans. Written pre-discharge plans identify each resident's needs and outline the type of setting and services the resident will most likely need upon discharge. These plans are updated periodically but no less often than annually.

Interviews revealed that it is the philosophy of SEVTC to provide residents preparing for discharge with adequate opportunities for visiting prospective placements so as to ensure a smooth transition to community living. Residents are encouraged to visit community placement options, including extended visits designed to determine how well the resident will function in the new setting. Facility staff work with community staff in order to assist the resident in adjusting to the new setting. These services, however, are limited because of the staffing patterns within the facility.

FACILITY OPERATIONS / SAFE ENVIRONMENT

1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.

SEVTC has multiple ways of assessing and monitoring the safety and security of the residential units. The facility's Building and Grounds Department conducts monthly safety checks of each of the buildings. Workers undergo specific safety training in addition to the overall training provided by the facility to all staff. The facility has a procedure in place for addressing work orders, which prioritizes work according to the

potential risk to the residents. Issues that would impact the life, health or safety of the residents are addressed first.

The facility has a Risk Management Committee that meets monthly to review areas targeted for monitoring and any other issues identified by staff. A review of the committee's minutes demonstrated that the committee addresses such topics as falls, resident-to-resident aggression, and emergency procedures. The committee develops plans of action and these are tracked until completed. The facility risk manager is a member of the committee and advises the group each month about the previous months critical incidents. The risk manager collects data on a number of variables. This is also shared with the group.

The facility has a morning reporting process that outlines significant events for the previous 24 hours. Members of the facility management team are present at the meeting and address issues as identified.

2. There are adequate safeguards to protect residents from abuse and neglect.

Interviews indicated that the protection of residents from abuse and neglect is addressed in several ways within the facility. Staff are educated about the rights of the residents as well as the identification and reporting of abuse and neglect during their preservice training. All staff receive annual updates in these areas. It was reported that the staff also receive Therapeutic Options for Virginia (TOVA) training, which provides skills building activities in effective communication and use of positive interventions in challenging situations so that the use of more restrictive procedures can be lessened.

Interviews with administrative and training staff indicated that the facility promotes the treatment of this vulnerable population with dignity and respect throughout all training experiences. Management of the facility reported that the abuse or neglect of the residents would not be tolerated. Management communicates to staff that the response to substantiated abuse and neglect will be definitive. Management also reports that efforts are made to promote an environment in which people will come forward to report these conditions. It was indicated that this is accomplished by treating staff fairly. Interviews revealed that management works hard to convey to staff an understanding that their jobs are difficult and that as incidents occur, every effort will be made to get to the truth.

Every morning the facility director, human rights advocate, risk manager and other senior managers meet to review the significant events for the preceding day, including critical incidents. Interviews revealed that the facility director has instructed the risk manger to informally review all events within the first 24 hours to rule out abuse and neglect as a potential component. This includes unexplained injuries. If this review results in a "reason to suspect abuse and neglect", the risk manager files an allegation. An investigation is then conducted. The advocate reviews all allegations of abuse and neglect and monitors the investigation on behalf of the consumer.

Interviews revealed that the facility director takes the investigation process very seriously. The director reviews the findings with senior management in order to identify any performance improvement initiatives that could prevent the incident from occurring again. There were 13 allegations of abuse and/or neglect made during the first six months of 2004. One of the allegations was substantiated.

3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.

The facility risk manger tracks critical incidents, both those that fit the criteria for reporting to VOPA and those incidents that impact patient safety but do not result in injuries such as the number of falls and peer to peer aggression. Thirty-four critical incidents were reported by this facility during the first six months of 2004. In addition, there were 141 incidents of peer-to-peer aggression, all of which resulted in an injury to one of the residents involved. Many of the injuries were minor cuts and abrasions, which did not require physician intervention. Performance improvement teams have been designed to address issues identified through this review. As noted above, the risk manager, facility director, abuse and neglect investigator, and the advocate meet every morning to review all incidents. As a result of this meeting additional information regarding events is sought through a variety of avenues.

An active healthcare system was identified as one of the mechanisms used by this facility to safeguard the residents from critical or life threatening incidents. In-service training designed to teach all staff how to recognize health problems in this population is routinely offered. Recently the facility upgraded its medical emergency response system. A nurse response team, comprised of two nurses on each shift, is available to address any emergencies on campus. The response team is dispatched through the admission office.

4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.

Interviews with both administrative and direct care staff provided evidence that the facility implements restrictive procedures according to the policy. SEVTC uses isolated time out within the facility. Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room." SEVTC complies with the CMS regulations, which outline the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program
- The use of the time-out room can not be used as an emergency intervention
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

Staff members in the behavioral cottage were able to identify the circumstances in which residents would be placed in isolated time out. The circumstances, as explained, were consistent with policy. Staff reported that they try less restrictive interventions before initiating isolated time out. SEVTC used isolated time-out 529 times during 2004. The maximum number of times any of the other 4 training centers used this most restrictive technique during the same period was 15 times.

Staff receive training in behavioral management. Staff related that as a safeguard, procedures have been established for the use of restrictive interventions. Any restrictive procedures that are to be used must be contained in an approved plan that is monitored by a qualified mental retardation professional (QMRP). There were 104 residents on approved behavioral plans at the facility during June 2004. At the time of the inspection, the team was informed that 95 residents had been prescribed a protective restraint.

5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.

Human Rights training is provided for all staff at the time of their orientation and then again annually. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. They are provided with a copy of the human rights "blue book". Documentation of notification of their rights was noted in the resident records reviewed.

The facility has both an informal and formal process for handling complaints. The facility handled four informal complaints and 2 formal ones during the first six months of 2004.

6. Medication usage is appropriately managed.

Interviews with nursing supervisors and direct care staff revealed that staff are trained in medication management, including recognizing potential side effects. This training was described as extensive and consists of modules designed to address issues required by the Board of Nursing for certification. All appropriate staff are also required to undergo an annual re-certification review.

Staff are expected to alert the primary nurse when any changes in the resident's health status is noticed. Logs are maintained regarding the administering of medications and are checked by unit supervisors. The psychiatrist and staff physician monitor the use of psychotropic medications. On-going pharmacy reviews provide an additional level of oversight regarding the use of medications to assure that they are appropriately managed. Medication errors are documented and reviewed. Additional training and supervision is provided as necessary.

7. There are mechanisms to address areas of concern regarding staff safety.

Interviews with administrative and direct care staff revealed that staff at the facility are expected to report injuries in a timely manner. The facility Quality Management Committee tracks workplace safety issues such as staff injuries and workmen compensation claims. Data is maintained regarding the type of employee injuries, location where the injuries occurred and the staff positions involved. This information is reviewed in a number of arenas such as risk management, quality assurance, human resources and the facility's safety committee. Environmental safety checks identify and correct physical conditions that could have an impact on the safety of the staff and residents. Staff are encouraged to report any areas of perceived risk for injury.

FACILITY OPERATIONS / LIVING ENVIRONMENT

1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.

In all of the areas toured, there was evidence that the residents have the opportunity to personalize their spaces. Individual rooms are decorated with personal items such as pictures of families and outings or other events significant to the residents. There was evidence of a concerted effort to make the settings appear more home-like. Residents are afforded privacy. Blinds or window coverings are provided, although the majority of the blinds in Building 28 were broken.

2. The residential environment is clean, odor free and well maintained.

Tours were completed in Cottages 1A, 2A, 4A, two units in Cluster 5 and in Building 28. There was wide variation in the condition of the inside of the buildings toured. This ranged from obviously run down and not well maintained (Building 28) to units very well maintained (Cluster 5 units). This was true for both the general repair of the interior spaces (painting, walls kept in good repair) and for the cleanliness and neatness of the environment. All of the units were clean, generally well maintained and odor free, except for Building 28. In Building 28, there were three bedrooms in which several knobs were missing from the dressers leaving exposed screws sticking out of the wood. Two dressers were broken resulting in the drawer fronts hanging down. Blinds in a majority of the bedrooms were torn or needed repairs. In one section of the hallway, a number of ceiling tiles were missing. In one of the bathrooms, the shower floor was dirty and two of the toilets appeared unclean.

The outside of many of the buildings appeared to be in bad condition. Wooden panels on the outside were clearly weatherworn, even when the paint was in OK condition. Many roofs looked like they needed extensive work.

In general, the grass was cut. However, in the areas where the grass needed cutting, like around several parking areas, the grass was extremely high, suggesting that it had not been cut in several weeks. Around many of the buildings and in the flowerbeds there was tall grass and little evidence of efforts to keep these areas neat.

Interviews identified that the following are the three most critical capital improvement projects at the facility:

- To replace the roofs
- To have emergency generators installed
- The initiation of Phase One of campus renovations including the building of four cottages to replace the older outdated cottages currently used.

It was also identified that the facility did not have any projects that were currently approved and funded.

3. There is evidence that the residents are being taken care of by the facility.

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. Observations of the interactions between the staff and the residents revealed that the staff treated the residents with dignity and respect. Staff related to the residents in a caring yet professional manner.

4. The facility provides for access to primary health care that is coordinated and comprehensive.

On the day of the inspection, there were 196 residents on campus. The facility has two primary care physicians including the facility medical director, and one nurse practitioner. The facility also has a part-time psychiatrist. In addition, residents have access to a number of clinic services.

SEVTC uses a system of primary nurses who are assigned to particular units/cottages. It is the responsibility of the primary nurse to manage the overall healthcare of the residents. The primary nurses coordinate appointments, track interventions and complete routine documentation regarding the residents' health status. SEVTC has an infirmary that maintains 24 hour nursing coverage. The first responder to an emergency is an RN. The facility recently upgraded its emergency response team to assure that two RNs are present at all times. There is no physician on-site during the evening or night shifts, but an on-call system is utilized for providing coverage. Nursing staff reports an excellent on-call physician response time of usually less than five minutes.

5. The facility has a mechanism for accountability of resident's money.

There is a patient accounts division under the facility's Office of Fiscal Management that maintains records of the patient's money. Each person's QMRP is responsible for documenting the use of all resident funds. Receipts are required in order to maintain accountability for items purchased either by the resident or on behalf of the residents.

FACILITY OPERATIONS / STAFFING PATTERNS

1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.

Interviews with 12 staff members, including administrative, clinical and direct care staff indicated that the facility maintained sufficient qualified staff to address the safety and supportive care needed by the residents. The majority (7) indicated that the facility did not always have a sufficient complement of staff to create the active treatment environment necessary to address the training needs of the residents in a consistent manner. They linked this to the challenges faced by the facility in recruiting staff. Six job fairs have been held at the facility in the past six months. Last June, during the first open house there were 150 persons present. Interviews were held and all the vacancies at the time were filled. The facility also tries to hire part-time pool employees to supplement regular staff when it is necessary.

During the tours, it was noted that in Building 28, the ratio of staff to residents was 4:1. There were 20 residents present and 5 staff members, one of which was a unit supervisor. In 1A, during the first shift, there were 6 residents present. Three of the residents on this unit had gone to Busch Gardens for the day, and one other was off the unit. Two staff members were present and an additional staff member was off the unit with a resident. In 4A and 2A, there were two staff present for eight residents during the evening shift. In 5A and 5B, there were 4 staff members present for eight residents.

Observations of staff assisting the residents in completing their preparations for bedtime exemplified the need for additional staff. In one cottage, one staff member was assisting a resident with his bath, while the other staff member present watched the other residents. Two of the residents were clearly ready for bed; one was falling asleep at the table and the other keep stating she wanted to go to bed. The staff member informed the resident that she could go to bed as soon as she had her bath. The team was informed that the resident was scheduled to get her bath next. The staff member indicated that she felt guilty not being able to meet the resident's request but with only the two of them, they were doing the best that they could.

2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of client supports and care.

Interviews with administration, human resources and staff indicated that staff turnover for the facility is relatively low but that there is a great deal of competition for healthcare workers in the Tidewater area and that other employers pay higher salaries, which impacted the facility's ability to recruit employees. The facility maintains adequate staffing through overtime and part-time positions.

3. Direct care staff possesses the competencies necessary for providing services.

Interviews with training and supervisory staff as well as a review of the training materials revealed that the majority of critical tasks associated with carrying out staff duties are based on competency reviews, which involve either tests or demonstrations.
The level of competency required for most of the critical tasks is 90%. Those individuals who are not able to meet the criteria are provided with opportunities to learn the material and be re-tested.

FACILITY OPERATIONS / SYSTEM PERFORMANCE

1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.

Data collection occurs in a variety of forms within the facility. Both risk management and quality assurance staff track a number of performance improvement measures. The Office of Information Technology was instrumental in the development of an automated record keeping system. In addition there is a database for the tracking of medication use.

2. There is a system for continuous quality improvement.

SEVTC has a system for continuous quality improvement. Information is tracked and reviewed by the Quality Management Committee at the facility. Some of the dimensions of care reviewed are preventative health screenings, medication errors, PRN usage, contractures, lab services, infection control, active treatment and use of behavioral procedures.

3. Consumers and other stakeholders have an active role in program development, and quality improvement activities.

Consumers and their families are not a formalized part of the Quality Assurance Process within the facility. However, interviews revealed that the facility is open to input from both. The facility director meets regularly with executives from the community services boards in the region.

COMMUNITY RELATIONSHIPS

1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in their catchment area.

Most of the work that surrounds maintaining community relationships takes place in the context of the interactions that occur as a result of providing services to the residents through the admissions, discharge and outreach processes. As noted, the facility director meets quarterly with the executive directors of the community services boards in the region. In addition, he meets with the CSB MR Directors monthly. Staff from the facility provides consultation to community providers in order to assist them in managing

their more challenging consumers but this does not happen with the frequency that facility staff would like because of the lack of resources to support this activity.

2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:

a. With Community Services Boards

No formalized surveys have been conducted with the CSBs

b. With parents and/or legally authorized representatives

The facility has not conducted any formal surveys with families but solicits feedback from them regularly on an individual basis. It was indicated that families are very willing to discuss any issues or concerns when they arise. They also are noted for praising the work of the facility, when appropriate.

c. With the DMHMRSAS Central Office

The facility indicated that there has not been a formalized satisfaction survey process completed with the CO other than the director's performance evaluation and at times when there are budget requests. It was noted that the CO has proven to be a valuable resource for the facility in the following areas: human resources, the budget office, risk management and quality management.

3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.

Even though the facility management had a working understanding of the capacity of the community to provide services to increasingly complicated clients, interviews with direct care staff indicated that the majority of staff did not. Most spoke of residents that had been discharged who returned to the facility as "failures", noting that their condition was much worse than went they left. Ten of the twelve staff members interviewed indicated that the community serves mild or moderate mentally retarded clients who do not have behavioral or medical challenges. Direct care staff indicated that the community could not provide the staffing patterns necessary to assist the residents in the same manner that the facility was able to do.

Most of the staff interviewed indicated that the facility served as the safety net for the community by accepting and training individuals who could not receive the services they need within the community

4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.

The facility has the capacity to provide services for all ages from children to geriatric consumers. SEVTC is licensed by DMHMRSAS to provide services for children under the age of 18. It was reported that the facility did not have any requests for respite services during the period of July 1, 2003 to July 1, 2004.

FINDINGS AND RECOMMENDATIONS

Finding 1: The majority of staff interviewed, including administrative, clinical and direct care staff, indicated that the facility did not have a formalized mission statement.

Recommendation: It is recommended that SEVTC develops a mission statement with broad-based staff participation and assure that the mission statement is consistent with the system-wide DMHMRSAS Vision Statement.

Finding 2: SEVTC used isolated time-out 529 times during 2004. The maximum number of times any of the other 4 training centers used this most restrictive technique during the same period was 15 times. One of the other four training centers has been able to eliminate the use of use of isolated time-out and has banned the use of the technique.

Recommendation: It is recommended that SEVTC take immediate steps to drastically decrease or eliminate the use of isolated time-out.

Finding 3: There was evidence that Building 28, in particular, and the grounds, in general were not well maintained during the time of the facility inspection.

Recommendation: It is recommended that SEVTC develop a specific mechanism for tracking the condition and maintenance of Building 28 as this residential unit has been and continues to be the site with numerous environment of care issues.

Finding 4: Staffing patterns were not adequate to allow for the active engagement of residents in training/treatment programs.

Recommendation: It is recommended that SEVTC review staffing patterns and deployment of staff to assure that the complement available allows for the active treatment of residents.

Finding 5: Space for vocational programming and other non-residential unit training activities is not adequate.

Recommendation: It is recommended that DMHMRSAS place the highest priority on adding additional facility space for vocational programming and other non-residential unit training activities.